Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CASA VIEW CHIROPRACTIC CLINIC
10622 SHILOH RD
DALLAS, TX 75228

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-1782-01

MFDR Date Received
JANUARY 25, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Blackwell examined [injured employee] for the purpose of determining whether or not she had reached maximum medical improvement, determine impairment rating, and determine the ability of the employee to return to work from her on the job injury. The CPT code that was used to bill this claim was 99456, and WP, and W8 the billed amount of $900 in accordance with TDI guidelines. "

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider submitted a bill with CPT Code 99456 W8. This CPT code is utilized for designated doctor exams performed to evaluate ability of the employee to return to work. See 28 TAC §134.204(i)(1(E). No other billing codes were submitted by the provider with its request for medical dispute resolution. Based upon CPT Code 99456 W8, the provider is entitled to reimbursement of $500. See 28 TAC§§ 134.204(i)(1)(E) and 134.204(k). The provider received $650 payment from carrier for this bill. As such, there is a $150 overpayment. The carrier requests that the provider submit a refund to the carrier in the amount of $150."

Response Submitted by: Flahive, Ogden & Latson, P.O. Box 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 7, 2011	99456-W8	$250.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for the reimbursement of workers' compensation specific services rendered on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated October 19, 2011

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- W1 – Workers' Compensation State Fee Schedule Adjustment.

Explanation of benefits dated November 14, 2011

- 18 – Duplicate claim/service.
- 247 – A payment or denial has already been recommended for this service.

Issues

1. What are the guidelines when billing for a Designated Doctor (DD) examination in accordance with 28 Texas Administrative Code §134.204?
2. Was the DD exam reimbursed appropriately per 28 Texas Administrative Code §134.204(j) & (k)?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204(i)(A), (B) & (E) state, "(A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor; (B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor; and (E) Ability of the employee to return to work shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W8";

   28 Texas Administrative Code §134.204(j)(3) (C) sates, An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350.

   28 Texas Administrative Code §134.204(j)(4)(C) (ii)(II), (a) & (b) state, The MAR for musculoskeletal body areas shall be as follows: (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area.

   28 Texas Administrative Code §134.204(j)(4)(C) (iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR.

   28 Texas Administrative Code §134.204(k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.
2. Review of the requestor's documentation supports that a Division ordered DD examination was completed by the requestor to determine maximum medical improvement (MMI), impairment rating (IR) and to determine the injured employee's ability to return to work (RTW). The requestor originally billed the MMI/IR and RTW exams with CPT Code 99456-WP (3 units). Upon reconsideration the requestor billed with CPT Code 99456-W8 (3 units). The respondent previously reimbursed the amount of $650.00.
3. In accordance with 28 Texas Administrative Code §133.20 (c), A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills. Therefore, Additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 27, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.